

Effects of Military Trauma Exposure on Women Veterans' Use and Perceptions of Veterans Health Administration Care

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BACKGROUND: Few studies have addressed how military trauma exposure, particularly sexual assault and combat exposure, affects women veterans' use and perceptions of Veterans Health Administration (VHA) care.

OBJECTIVE: The aim of the present study was to evaluate the effects of military sexual assault and combat exposure on women veterans' use and perceptions of different aspects of VHA care.

DESIGN: Cross-sectional telephone survey of a national sample of women veterans.

PARTICIPANTS: Women from the VA's National Registry of Women Veterans.

MEASUREMENTS: Sociodemographic characteristics, VHA care utilization, perceptions of care.

RESULTS: Women veterans with histories of military sexual assault reported more use of VHA services, but less satisfaction, poorer perceptions of VHA facilities and staff, and more problems with VHA services compared to women veterans without histories of sexual assault. Combat exposure was related to more problems with VHA staff, although few other differences were observed for women with and without histories of combat exposure.

CONCLUSIONS: Findings provide information on areas that can be targeted with respect to caring for women veterans exposed to military sexual trauma and combat exposure, including improving interactions with VHA staff and the ease of using VHA services.

KEY WORDS: women's health; sexual assault; combat exposure; veterans; access to care.

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makeup of the Veterans Health Administration (VHA) patient population. Women veterans now represent approximately 5.5% of patients in VHA facilities, and are one of the fastest growing patient populations within the VHA.¹ In response to these changes, more emphasis has been placed on the status of women veterans' health care services and utilization.^{1,2}

As women's representation in the military continues to grow, they are increasingly at risk for various types of trauma exposure during their military service, including sexual assault and combat. Although research has shown that female trauma survivors are more likely to use health care services, especially mental health care services, compared to male trauma survivors,^{3,4} the overwhelming majority of patients who obtain care at VHA facilities are men. Given that the primary patient population served by VHA consists of military veterans, negative experiences that occur in the military could trigger negative memories and discomfort within the VHA setting for some women veterans, contributing to poorer perceptions of the VHA care environment compared to other facilities.^{5,6} Thus, it is important to understand how military trauma, including military sexual assault and combat exposure, affects women veterans' use and perceptions of VHA services.

The literature indicates that rates of sexual assault are significantly higher for women veterans compared to female civilians.⁷ Women with a history of sexual assault report more physical health complaints⁸⁻¹⁰ and are more frequent users of health care.^{9,11} Similar findings have been observed for women veterans who use VHA care.^{7,12-14} Research has also shown that female survivors of military sexual assault often experience more distrust and blame directed at medical staff, depression/anxiety, and reduced willingness to seek further help at military/VHA health care settings compared to women who have sought treatment for sexual assault at civilian facilities.¹⁵ However, few studies have addressed how the experience of military sexual assault affects perceptions of specific health care-related dimensions (e.g., perceptions of medical professionals, characteristics of the health care setting) that may influence women veterans' use and satisfaction with VHA care.

Even less is known about how combat exposure affects health care utilization and perceptions of care in women veterans. Yet, this is an important area for further investigation given that women are increasingly at risk of exposure to combat trauma.^{16,17} Although there is little literature on the effects of combat exposure for women, results based primarily

With an increasing number of women entering the military, there has been a corresponding shift in the

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on male samples have revealed that combat duty is associated with more mental and physical health problems,^{18–20} and higher rates of health care utilization.^{16,20,21} In addition, findings have shown that male veterans with and without histories of combat exposure do not differ in their satisfaction with VHA care,²² although stigma related to the treatment of mental health problems has been found to be a significant barrier to care for this population.²⁰ Women veterans deployed during the Gulf War showed a trend toward higher use of outpatient health care than male veterans.²³ However, little research has addressed how combat exposure affects women veterans' perceptions of health care, including VHA care.

The aim of the present study was to investigate the effects of military sexual assault and combat exposure on women veterans' use of VHA services and perceptions of VHA care. In addition, although depression and higher levels of psychological distress more generally have been associated with more negative perceptions of health care,^{24,25} to date, few studies have controlled for depression in evaluating how trauma affects perceptions of health care. Thus, an additional goal was to examine the unique contributions of military sexual assault and combat exposure to women veterans' perceptions of VHA care, after accounting for the contribution of depressive symptoms to perceptions of care.

METHOD

Participants

Participants were obtained from the National Registry of Women Veterans (NRWV), a database that was used to track US women veterans. Participants were selected using a stratified sampling design. This design included 12 strata: 3 age groups, representing pre-Vietnam, Vietnam, and post-Vietnam cohorts (over 50, 35–49, and under 35 years), 2 racial groups (black and non-black), and 3 VHA user groups (nonusers, former users, and current users). Smaller strata were oversampled (e.g., African Americans under 35) to facilitate group comparisons. Of the 5,030 individuals that were originally selected, 1,959 potential participants were contacted ($n=2,982$ had invalid or unpublished telephone numbers, $n=89$ could not be contacted by telephone or correspondence). Of the 1,959 people who were contacted, 1,662 were eligible to participate and could be categorized according to study strata. Of these 1,662 potential participants, 90% agreed to participate. The final sample was constituted of 1,496 participants who provided information on exposure to military sexual assault and combat.

All participants were asked about their history of sexual assault in the military with the following question: "While you were in the military, did you have any experience where someone tried to use force or the threat of force to make you have sexual relations against your will?" A history of combat exposure was assessed with the following question, "During your military service, were you ever in or exposed to combat situations, such as flying in an aircraft over a combat zone, receiving incoming fire from enemy artillery, rockets or mortars, receiving sniper or sapper fire, or seeing Americans being killed or being wounded?" Participants provided affirmative or neg-

ative responses for these two questions. Of the 1,496 participants, 288 (19%) reported that they experienced military sexual assault, 137 (9%) reported at least 1 episode of combat exposure, and 37 (2%) indicated that they were exposed to both sexual assault and combat.

Procedure

Surveys were administered to participants via a computer-assisted telephone interviewing (CATI) system. Data were collected in 1997 and interviews averaged approximately 45 minutes. All participants were assured that their responses were confidential and that their participation would not affect their use and quality of VHA services. Materials and procedures were approved by the facility's institutional review board.

Measures

Sample Characteristics and Health Status. All participants were assessed on number of background characteristics (i.e., age, race, marital status, household income, insurance coverage, educational attainment, and service-connected disability status), and mental and physical health. Physical health status was assessed with the Medical Outcomes Study Short Form 36 (SF-36) General Health Survey item on self-reported physical health (potential range of scores=0–4).^{26,27} Physical functioning was assessed with the Physical Functioning Subscale of the SF-36 (potential range of scores=0–100).^{26,27} The Center for Epidemiologic Studies Depression Scale (CES-D)²⁸ was used to measure symptoms of depression (potential range of scores=0–60). The PTSD Checklist (PCL),^{29–31} a measure of posttraumatic stress disorder symptoms (potential range of scores=17–85), was only administered to study participants who endorsed traumatic experiences during the military ($N=926$), including serious disasters or accidents, a serious illness, criminal or personal victimization (including sexual assault), and combat exposure. Responses to these items were referenced to "stressful military experiences" generally, rather than to one specific trauma.

Use and Perceptions of VHA Care. All participants were asked about their use of VHA services and were categorized as current users (i.e., use within the previous 2 years), former users (i.e., use within 3–10 years), and non-users (no use, or use more than 10 years ago). Participants were asked to rate their perceptions of the quality of VHA services using a 5-point response format ranging from "poor" to "excellent." In addition, a dichotomous item was used to assess whether participants believed that VHA care was "mostly for men." Participants were also asked to report on the degree to which this kept them from using VHA services using a 4-point response format from "not at all" to "greatly."

Satisfaction and Barriers to Care. Former and current VHA users rated their overall satisfaction with VHA services using a 5-point response format, from "very dissatisfied" to "very satisfied." In addition, these participants completed a measure that involved comparing their experiences and impressions of VHA care with those of other health care

facilities on several dimensions, including the availability of services, doctors' skills and sensitivity, logistics of care, and facility characteristics.³² Items were rated using a 5-point response format, from "much worse" to "much better." Mean scores were calculated for each of these 4 scales. Internal consistency reliability estimates for subscales of this measure ranged from $\alpha=0.74-.90$ in the current sample.

Former and current VHA users completed another measure that required them to rate the extent to which problems with a number of VHA characteristics interfered with their use of VHA care.³² This measure addresses 3 domains, including problems with accessing women-specific/women sensitive care, problems with VHA doctors/staff, and problems with the ease of using VHA facilities. Items were rated using a 4-point response format, from "not at all" to "greatly." Mean scores were calculated for the 3 scales. Internal consistency reliability estimates for subscales of ranged from $\alpha=0.69-.79$ in the current sample. Because of significant positive skewness, problems with accessing women-specific/women-sensitive care and problems with VHA doctors/staff were log-transformed for all analyses. The log transformations resulted in a normal distribution for both variables.

Statistical Analyses

Chi-square difference tests and independent samples *t* tests were used to examine differences in demographic variables and health status as a function of military sexual assault and combat exposure. A series of independent samples *t* tests was next employed to analyze differences in participants' use and perceptions of VHA care as a function of military sexual assault and combat exposure for the total sample. A second set of independent samples *t* tests was employed to examine differences in satisfaction with VHA services and reported barriers to care for former and current VHA users. A Holm's modified Bonferroni procedure^{33,34} was adopted to control for error as a result of these multiple comparisons for both trauma groups. The minimum modified Bonferroni *p* values were set at $p<.013$ for the first set of analyses and $p<.006$ for the second set of analyses. Finally, linear regression analyses were used to examine the unique contributions of sexual and combat trauma to perceived barriers to care, with depressive symptoms entered as a covariate.

RESULTS

Demographic/Background Characteristics and Health Status

Military Sexual Assault. Participants with a history of military sexual assault (MSA) were significantly younger than participants without a history of MSA (NMSA). In addition, MSA participants were less likely to have health insurance in the past 2 years, more likely to have a service-connected disability, and reported significantly higher levels of depression, more symptoms of PTSD, lower perceived health status, and poorer physical health functioning than NMSA participants (see Table 1).

Table 1. Demographic/Background Characteristics and Health Status as a Function of Military Sexual Assault

	NMSA	MSA	<i>p</i>
Age in years, mean (SD)	43.60 (15.01)	40.56 (10.60)	.001
Race, <i>n</i> (%)			n.s.
White, nonhispanic	769 (64.2)	183 (64.0)	
Black, nonhispanic	345 (28.8)	80 (28.0)	
Asian/Pacific Islander/Native American/Alaskan Native	16 (1.3)	7 (2.4)	
Hispanic	45 (3.8)	9 (3.1)	
Other	22 (1.8)	7 (2.4)	
Marital Status, <i>n</i> (%)			n.s.
Married	581 (48.3)	123 (42.7)	
Divorced	225 (18.7)	70 (24.3)	
Separated	44 (3.7)	15 (5.2)	
Widowed	76 (6.3)	12 (4.2)	
Single	278 (23.1)	68 (23.6)	
Educational Attainment, <i>n</i> (%)			n.s.
High school graduate or less	339 (28.2)	68 (23.6)	
Some college	506 (42.1)	139 (48.3)	
College	202 (16.8)	52 (18.1)	
Postgraduate	156 (13.0)	29 (10.1)	
Insurance Coverage, <i>n</i> (%)			.031
Had in the past 2 years	877 (73.0)	188 (65.3)	
Part of the past 2 years	152 (12.7)	45 (15.6)	
Not in past 2 years	172 (14.3)	55 (19.1)	
Household Income, <i>n</i> (%)			n.s.
Less than \$14,999	211 (18.3)	59 (20.9)	
\$15,000–\$29,999	375 (32.6)	105 (37.2)	
\$30,000–\$49,999	327 (28.4)	75 (26.6)	
\$50,000 or more	238 (20.7)	43 (15.2)	
Service-connected disability, <i>n</i> (%)			.005
None	734 (64.8)	151 (56.6)	
10% to 50%	298 (26.3)	81 (30.3)	
51% to 99%	32 (2.8)	18 (6.7)	
100%	68 (6.0)	17 (6.4)	
CES-D Score, mean (SD)	11.29 (11.13)	17.71 (14.89)	<.001
PCL Score, mean (SD)	24.67 (11.53)	35.46 (18.52)	<.001
Health Status, mean (SD)	3.29 (1.16)	3.06 (1.20)	.002
Physical functioning, mean (SD)	77.97 (26.27)	72.02 (27.84)	.001

% = % within group; NMSA = no military sexual trauma; MSA = military sexual trauma; CES-D: Center for Epidemiological Studies Depression Scale; PCL: PTSD Checklist.

Combat Exposure. Participants with a history of combat exposure (CE) had a higher level of education and were more likely to have a service-connected disability compared to participants without combat exposure histories (NCE). CE participants also reported significantly more depression, PTSD symptoms, and lower perceived health status than NCE participants (Table 2).

Use and Perceptions of VHA Care

Military Sexual Assault. MSA participants were more likely than NMSA participants to report having used VHA services. The quality of VHA care was rated significantly lower by MSA participants than NMSA participants. Significantly more MSA participants reported that they believed that VHA care was geared toward male patients and that this resulted in greater interference with their use of VHA services compared to NMSA participants (Table 3).

Table 2. Demographic/Background Characteristics and Health Status as a Function of Combat Exposure

	NCE	CE	p
Age in years, mean (SD)	42.98 (14.14)	43.52 (15.89)	n.s.
Race, n (%)			n.s.
White, nonhispanic	862 (64.0)	90 (65.7)	
Black, nonhispanic	389 (28.9)	37 (27.0)	
Asian/Pacific Islander/Native American/Alaskan Native	19 (1.4)	4 (2.9)	
Hispanic	51 (3.8)	3 (2.2)	
Other	26 (1.9)	3 (2.2)	
Marital Status, n (%)			n.s.
Married	649 (47.8)	54 (39.4)	
Divorced	275 (20.3)	25 (18.2)	
Separated	50 (3.7)	8 (5.8)	
Widowed	75 (5.5)	12 (8.8)	
Single	308 (22.7)	38 (27.7)	
Educational Attainment, n (%)			<.001
High school graduate or less	382 (28.2)	23 (16.8)	
Some college	595 (43.9)	52 (38.0)	
College	226 (16.7)	29 (21.2)	
Postgraduate	153 (11.3)	33 (24.1)	
Insurance Coverage, n (%)			n.s.
Had in the past 2 years	968 (71.3)	99 (73.3)	
Part of the past 2 years	183 (13.5)	14 (10.4)	
Not in past 2 years	206 (15.2)	22 (16.3)	
Household Income, n (%)			n.s.
Less than \$14,999	249 (19.2)	22 (16.3)	
\$15,000–\$29,999	437 (33.6)	42 (31.1)	
\$30,000–\$49,999	361 (27.8)	44 (32.6)	
\$50,000 or more	253 (19.5)	27 (20.0)	
Service-connected disability, n (%)			.016
None	815 (64.2)	70 (53.0)	
10% to 50%	339 (26.7)	42 (31.8)	
51% to 99%	45 (3.5)	5 (3.8)	
100%	70 (5.5)	15 (11.4)	
CES-D Score, mean (SD)	12.23 (11.97)	15.84 (14.17)	.001
PCL Score, mean (SD)	27.14 (13.96)	34.11 (19.13)	<.001
Health Status, mean (SD)	3.29 (1.17)	2.82 (1.09)	<.001
Physical functioning, mean (SD)	77.17 (26.67)	73.13 (26.72)	n.s.

% = % within group; NCE = no combat exposure; CE = combat exposure; CES-D: Center for Epidemiological Studies Depression Scale; PCL: PTSD Checklist.

Combat Exposure. CE participants reported that their perception that VHA care was more male-oriented caused significantly more interference with their use of VHA services than NCE participants. However, CE and NCE participants did not show significant differences on the basis of use of VHA services or perception of the quality of VHA services (Table 3).

Satisfaction with VHA Services and Barriers to Care

Military Sexual Assault. Former and current VHA users with histories of sexual assault and no sexual assault were asked about their satisfaction with and specific barriers to VHA care (Table 4). MSA participants reported less satisfaction with VHA care than NMSA participants. In addition, compared to NMSA participants, MSA participants reported that VHA care was significantly worse than other health care facilities on the basis of doctor characteristics, logistics of using VHA care, and VHA

facility characteristics (e.g., hours, parking). MSA participants also reported significantly more problems with accessing women-specific services, problems with VHA doctors/staff, and the ease of using VHA services.

Combat Exposure. CE and NCE participants did not significantly differ with regard to their satisfaction with VHA care. CE and NCE participants also did not differ with regard to their perception of VHA facilities, staff, and services. CE participants reported significantly more problems with VHA doctors/staff than NCE participants. Finally, combat exposure was not associated with more problems with accessing women-specific services, VHA doctors/staff, and the ease of using VHA services (Table 4).

Regression Analyses

The overall regression equation was not significant for the prediction of perceptions of the availability of VHA services compared to other health care facilities. All other regression models were significant (Table 5). Military sexual assault significantly predicted doctor characteristics, logistics of care, and facility characteristics, after accounting for the influence of both combat exposure and depressive symptoms. Military sexual assault was also associated with more negative perceptions of VHA doctors' sensitivity and skill, the logistics of care, and facility characteristics at VHA

Table 3. Use and Perceptions of VHA Care in the Total Sample as a Function of Military Sexual Assault and Combat Exposure

	NMSA	MSA	p
Use of VHA Services, n (%)			.004
No	457 (38.0)	83 (28.9)	
Yes	747 (62.0)	204 (71.1)	
Perception about the Overall Quality of VHA Care, mean (SD)	3.09 (1.22)	2.81 (1.31)	.001
VHA for Men, n (%)			<.001
No	411 (35.4)	60 (21.2)	
Yes	751 (64.6)	223 (78.8)	
Perception that VHA Services are for Men Affects Use, mean (SD)	0.69 (1.12)	1.10 (1.29)	<.001
	NCE	CE	p
Use of VHA Services, n (%)			n.s.
No	496 (36.6)	44 (32.1)	
Yes	861 (63.4)	93 (67.9)	
Perception about the Overall Quality of VHA Care, mean (SD)	3.04 (1.24)	2.97 (1.24)	n.s.
VHA for Men, n (%)			n.s.
No	429 (32.6)	41 (30.8)	
Yes	885 (67.4)	92 (69.2)	
Perception that VHA Services are for Men affects use, mean (SD)	0.75 (1.15)	1.05 (1.29)	.004

p values are derived from modified Bonferroni corrected chi-square or t tests, $p < .013$.

% = % within group; NMSA = no military sexual trauma; MSA = military sexual trauma; NCE = no combat exposure; CE = combat exposure.

Table 4. Satisfaction with VHA Care and Barriers to Care for Former and Current Users as a Function of Military Sexual Assault and Combat Exposure

	NMSA (n=747)	MSA (n=204)	p
Satisfaction with VHA Care	3.45 (1.17)	3.07 (1.27)	<.001
Comparison of VHA Care with Care at Other Facilities			
Availability of VHA Services	0.00 (0.88)	-0.24 (0.90)	.007
VHA Doctor Characteristics	0.11 (0.81)	-0.19 (0.86)	<.001
Logistics of VHA Care	-0.04 (0.87)	-0.31 (0.80)	<.001
VHA Facility Characteristics	0.20 (0.72)	0.00 (0.78)	.001
Extent to which Specific Problems Interfere with VHA Use			
Problems Accessing	1.25 (0.54)	1.59 (0.81)	<.001
Women-Specific Services*			
Problems with VHA Doctors/Staff*	1.18 (0.39)	1.39 (0.58)	<.001
Problems with Ease of Use	1.39 (0.54)	1.66 (0.64)	<.001
	NCE (n=861)	CE (n=93)	p
Satisfaction with VHA Care	3.37 (1.20)	3.24 (1.17)	n.s.
Comparison of VHA Care with Care at Other Facilities			
Availability of VHA Services	-0.05 (0.89)	-0.07 (0.81)	n.s.
VHA Doctor Characteristics	0.06 (0.83)	-0.09 (0.80)	n.s.
Logistics of VHA Care	-0.09 (0.87)	-0.18 (0.84)	n.s.
VHA Facility Characteristics	0.17 (0.74)	0.01 (0.77)	n.s.
Extent to which Specific Problems Interfere with VHA Use			
Problems Accessing	1.31 (0.60)	1.46 (0.79)	n.s.
Women-Specific Services*			
Problems with VHA Doctors/Staff*	1.21 (0.43)	1.37 (0.60)	.002
Problems with Ease of Use	1.44 (0.56)	1.54 (0.65)	n.s.

p-values are derived from modified Bonferroni corrected *t* tests; *p*<.006
NMSA = no military sexual trauma; MSA = military sexual trauma; NCE = no combat exposure; CE = combat exposure

*Analyses were computed for log-transformed variables

facilities compared to other health care facilities, after accounting for combat exposure and levels of depression. The effect of combat exposure, on the other hand, was only significant in one regression analysis; combat exposure was negatively associated with perceptions of facility characteristics, after accounting for the influence of military sexual assault and depressive symptoms.

In a similar manner, military sexual assault was a consistently significant predictor of problems with VHA care, after controlling for combat exposure and depressive symptoms. Military sexual assault was associated with more problems with accessing women-specific services, problems with doctors/staff, and problems with ease of using VHA services. In contrast, combat exposure was not associated with problems with VHA care, with one exception: a history of combat was associated with significantly more problems with VHA doctors/staff after accounting for the influence of military sexual assault and depressive symptoms.

DISCUSSION

Results revealed that military sexual assault was associated with greater use of VHA care, but less satisfaction with VHA services. Military sexual assault was also a better predictor of

specific problems with VHA care than combat exposure. Military sexual assault was strongly associated with poorer perceptions of VHA care as well as more problems with VHA doctors and staff, even after accounting for depressive symptoms, which may contribute to negative appraisals of VHA services. These results are important in light of the fact that women veterans who have experienced military sexual assault are more likely than women veterans without these experiences to have poorer health functioning as seen in the present study and in other studies,^{7,35,36} and in turn, tend to have higher rates of health care utilization.

The finding that combat exposure was not a significant predictor of problems with VHA care is encouraging. A few exceptions were observed: Compared to women with no combat exposure, women exposed to combat reported that they were less likely to use VHA care because they believed it was male-oriented, endorsed more problems with VHA doctors and staff, and indicated that they had lower opinions of VHA facility characteristics compared to other health care facilities. These results point to areas of VHA care that could be improved from the standpoint of women veterans with histories of combat exposure. As this group of women veterans is rapidly becoming a larger subgroup of VHA users,¹ it is important to address issues such as the quality of interactions between VHA staff and women veterans, which could improve these patients' satisfaction with VHA services.

One of the novel strengths of this study is the comparison of the effects of combat exposure and military sexual trauma on perceptions and use of VHA care in a nationally representative sample of women veterans. However, sampling bias may have been introduced by the self-selection of participants in the present study. Although we have identified relevant barriers to care for women veterans with a history of trauma exposure, more research is needed that focuses on specific reasons for these barriers to care. In addition, as the experience of multiple traumas, including sexual trauma and combat exposure, is associated with a greater risk of PTSD in military veterans,³⁷ women who experience both types of trauma are likely to have greater health care needs and more complex clinical presentations than women who experience either trauma alone. This may translate into unique barriers to care. Although the current sample was too small to examine potential barriers to care for women veterans who have experienced both military sexual trauma and combat trauma, further research is needed to address the unique barriers to care for these women veterans.

In conclusion, the results of this study point to several areas that might lead to improvements in addressing the needs of women veterans who have experienced military trauma. In particular, these findings point to the importance of addressing women veterans' perceptions of VHA care. Over the past several years, effort has centered on improving women veterans' experiences in the VHA setting (e.g., increasing the availability of providers with expertise in treating patients who have experienced sexual assault).³⁸ The current results support the need for these ongoing initiatives and provide additional information that can inform future efforts, especially highlighting the need for attention to interactions between

Table 5. Summary of Regression Analyses Examining Associations Between Histories of Military Sexual Assault, Combat Exposure, Depression, and Barriers of VHA Care among Former and Current Users

	R^2	B	SE	β	<i>t</i>	<i>p</i>
Comparison of VHA Care with Care at Other Facilities						
Model for Availability of Services [<i>F</i> (3, 545)=2.27, <i>p</i> =0.080)]	0.01					
Depression		0.000	.003	.006	0.14	.890
Military Sexual Assault		−0.234	.092	−.113	−2.54	.011
Combat Exposure		−0.002	.128	−.001	−0.02	.986
Model for Doctor Sensitivity and Skill [<i>F</i> (3, 885)=8.25, <i>p</i> <0.001)]	0.03					
Depression		0.004	.002	.063	1.82	.069
Military Sexual Assault		−0.320	.069	−.158	−4.61	<.001
Combat Exposure		−0.152	.092	−.055	−1.65	.100
Model for Logistics of Care [<i>F</i> (3, 852)=4.92, <i>p</i> =0.002)]	0.02					
Depression		0.001	.002	.008	0.23	.818
Military Sexual Assault		−0.269	.073	−.129	−3.66	<.001
Combat Exposure		−0.073	.098	−.025	−0.75	.457
Model for Facility Characteristics [<i>F</i> (3, 915)=8.38, <i>p</i> <0.001)]	0.03					
Depression		0.006	.002	.111	3.28	.001
Military Sexual Assault		−0.240	.061	−.132	−3.92	<.001
Combat Exposure		−0.174	.082	−.070	−2.12	.034
Extent to which Specific Problems Interfere with VHA Use						
Model for Problems Accessing Women-Specific Services* [<i>F</i> (3, 865)=27.64, <i>p</i> <0.001)]	0.09					
Depression		0.002	.000	.190	5.63	<.001
Military Sexual Assault		0.066	.013	.177	5.25	<.001
Combat Exposure		0.017	.017	.032	0.99	.325
Model for Problems with Doctors/Staff* [<i>F</i> (3, 919)=22.19, <i>p</i> <0.001)]	0.07					
Depression		0.002	.000	.162	4.90	<.001
Military Sexual Assault		0.043	.010	.145	4.41	<.001
Combat Exposure		0.029	.013	.071	2.21	.027
Model for Problems with Ease of Use [<i>F</i> (3, 911)=22.54, <i>p</i> <0.001)]	0.07					
Depression		0.008	.001	.179	5.40	<.001
Military Sexual Assault		0.209	.046	.149	4.50	<.001
Combat Exposure		0.048	.063	.024	0.76	.451

*Analyses were computed for log-transformed variables

women veterans and staff and the availability and ease of using VHA services. Additional research is necessary to determine more specific areas of improvement that could lead to reduced barriers to care for women veterans who have experienced military trauma.

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